



Healthcare Provider Awareness and Integration of Immunotherapy for Stage III NSCLC

Abstract #123

CLINICAL CARE OPTIONS[®]
ONCOLOGY

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Background

- Phase III PACIFIC trial: Anti-PD-L1 inhibitor, durvalumab, demonstrated survival benefit vs placebo^[1,2]
 - Median PFS: 16.8 vs 5.6 months (HR: 0.52; $P < .001$)
 - Median OS: NR vs 28.7 months (HR: 0.68; $P = .0025$)
- In February 2018, durvalumab approved for unresectable stage III NSCLC without progression after concurrent chemoradiotherapy (cCRT)^[3]
- Checkpoint inhibition is now considered by most experts to be standard of care in this setting

Methods

- 6 CME/CE-certified symposia conducted following the approval of durvalumab to provide healthcare providers (HCPs) with education on this new treatment option for unresectable stage III NSCLC
- 4 major clinical oncology conferences: NCCN, AACR, ASCO, SITC
- 2 managed care pharmacy (MCP) conferences: AMCP Annual, AMCP Nexus
- Self-identified practice trends obtained through case-based polling questions, which were asked before and then again after completion of the education
 - Identical questions repeated at each symposium

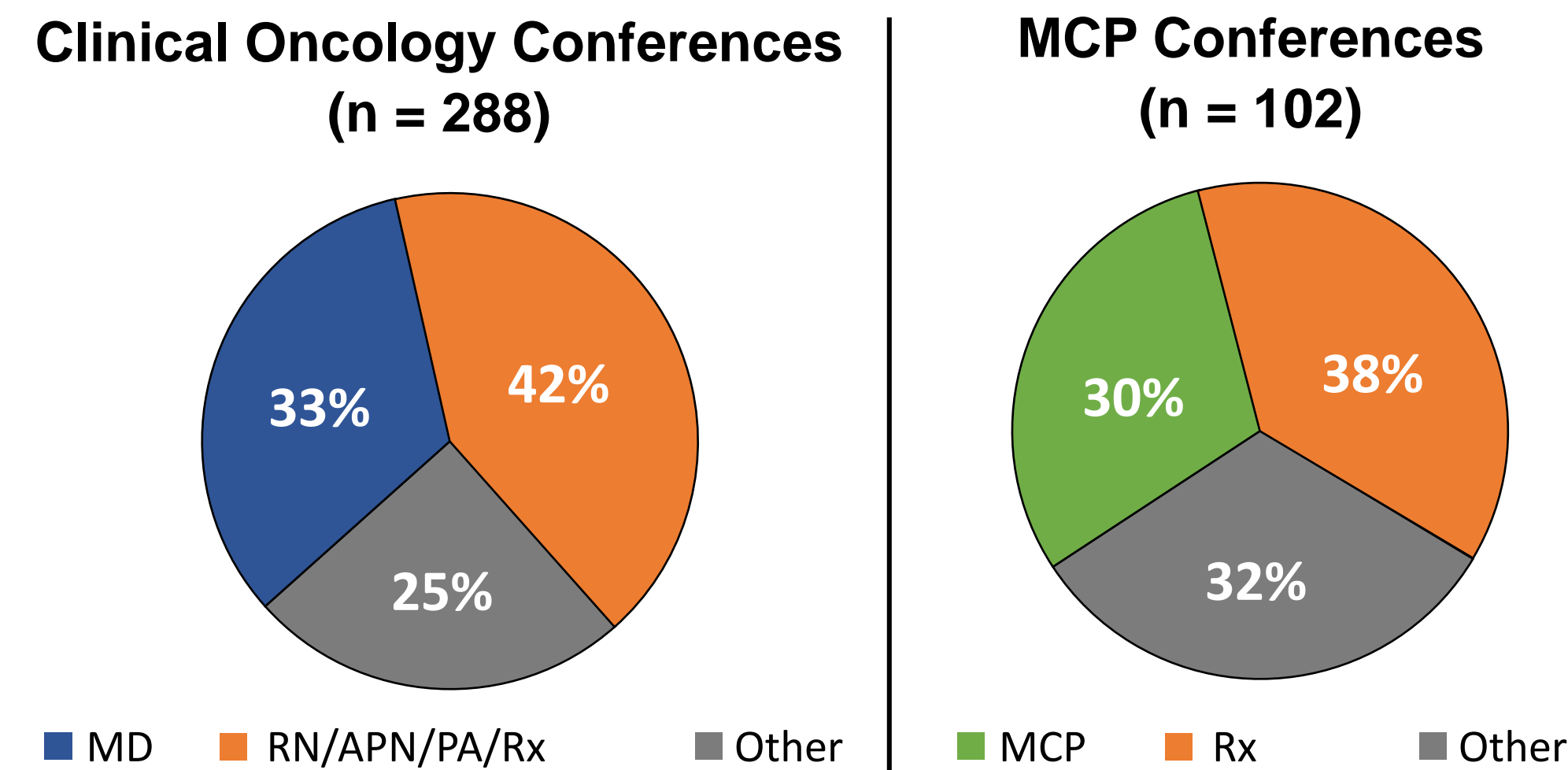
Symposia Timeline

Clinical Oncology Conferences



Results

Symposia Participant Demographics



Pre-Education HCP Knowledge & Practice Trends

- An average of 44% of HCPs recommended durvalumab consolidation for an ideal patient candidate with stage III NSCLC after cCRT
- An average of 31% of HCPs would recommended durvalumab for a duration of 1 year
- Physicians (77%) selected the optimal management of immune-related pulmonary toxicity more often than other HCPs (32% for RN/APN/PA/Rx, 11% for MCPs)
- Of interest, individual pre-education data sets across symposia and over time failed to show a clear trend in an increased utilization of durvalumab since its approval (data not shown)

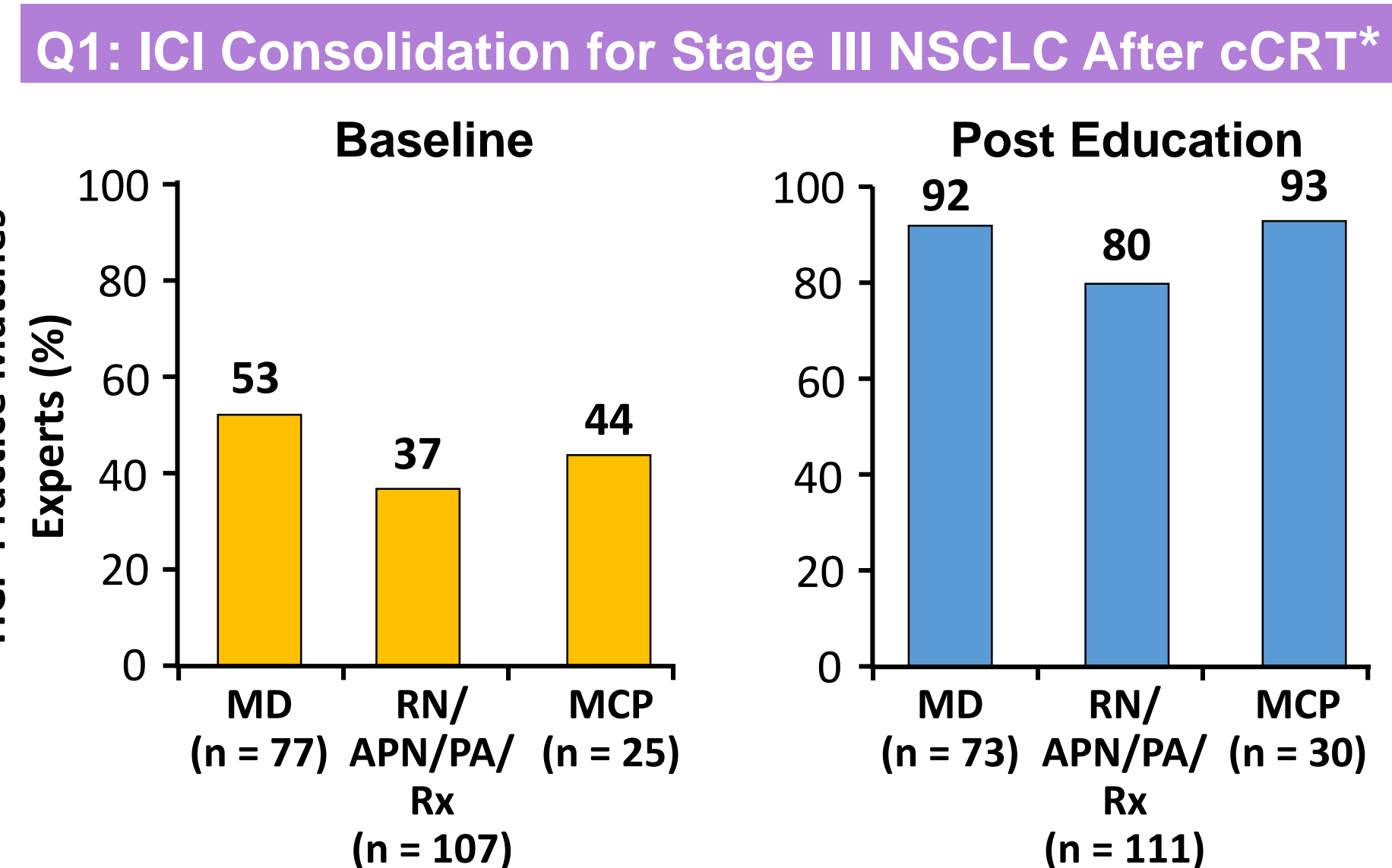
Post-Education HCP Knowledge & Practice Trends

- HCP competence significantly improved ($P < .0001$) in regard to selecting optimal immune checkpoint inhibitor (ICI) therapy and managing pulmonary toxicity

Additional Resources: Treatment Decision Tools

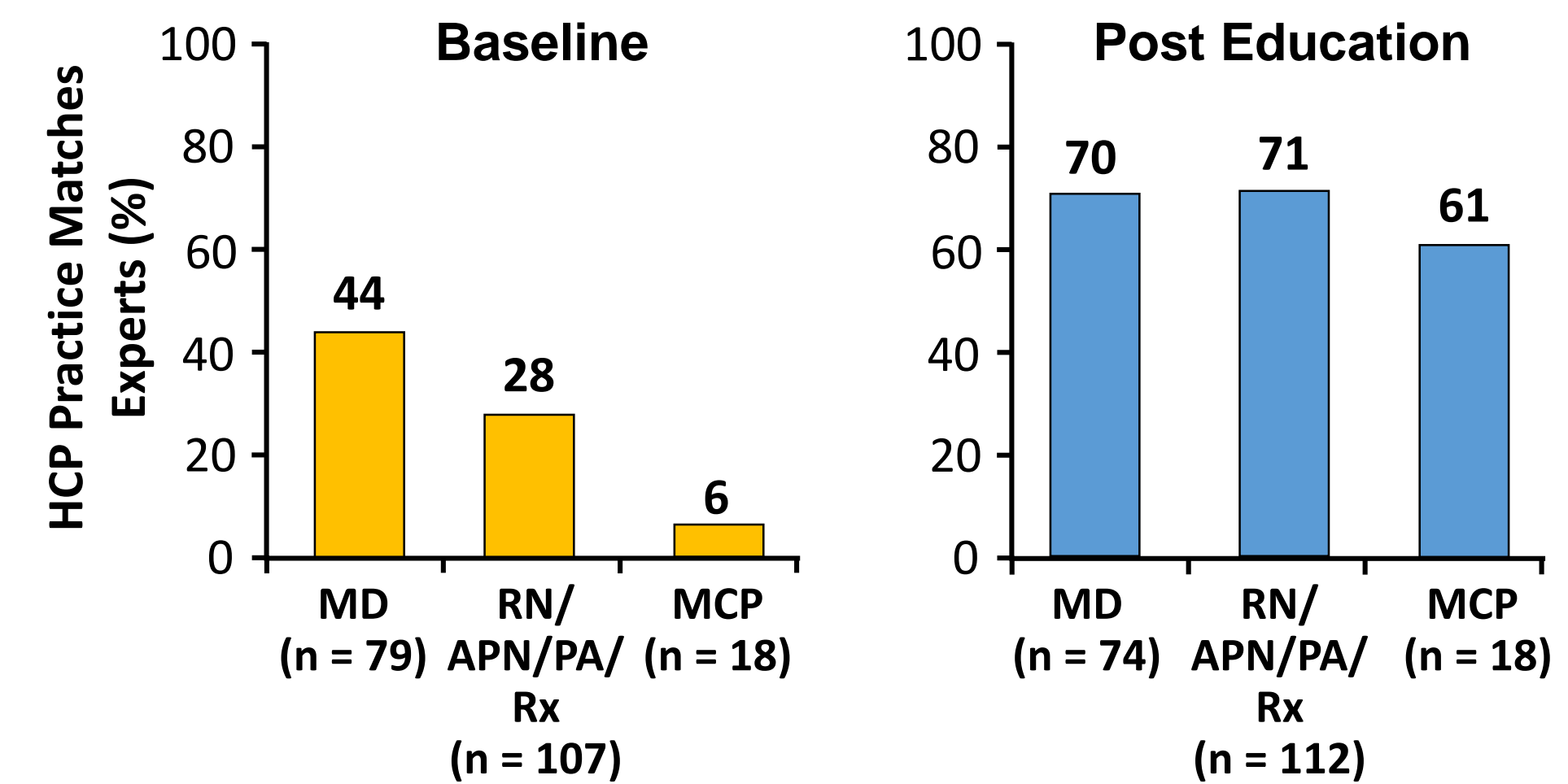
- Expert Insight on Therapy Selection for Unresectable Stage III and Metastatic NSCLC
www.clinicaloptions.com/LungTool
- NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines[®]) for Managing Immune Checkpoint Inhibitor-Related Toxicities:
www.clinicaloptions.com/immuneAETool

HCP Knowledge & Practice Trends by Specialty

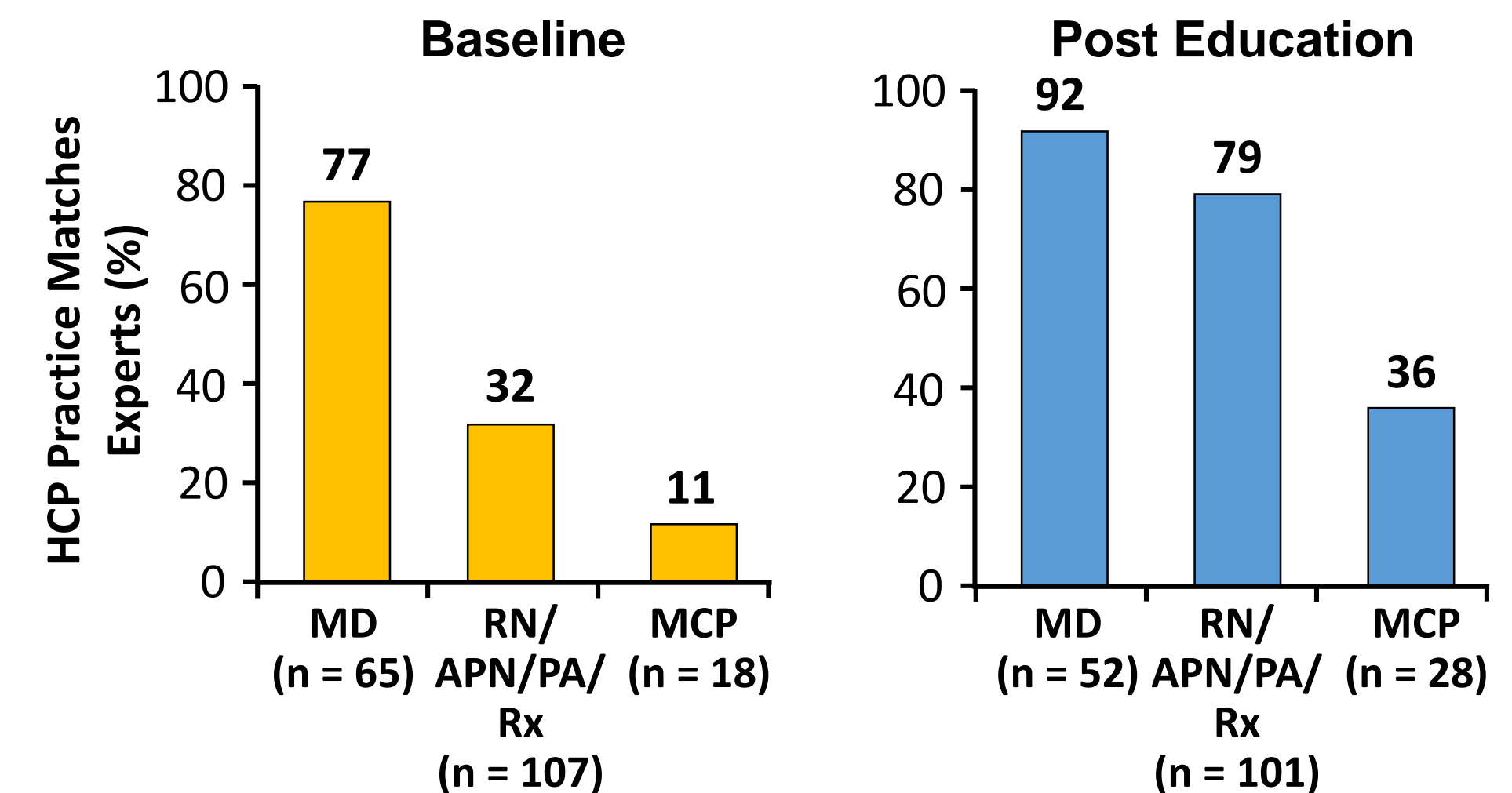


*CCO NSCLC treatment decision tool shows consensus among 5 experts to give ICI for stage III NSCLC after cCRT

Q2: Optimal Duration of ICI Therapy After cCRT



Q3: Management of Pulmonary Toxicity From ICI



Audience FAQs

- Are you checking PD-L1 status after cCRT? Would you give durvalumab to a patient with $< 1\%$ PD-L1 expression?
- Are there any comorbidities that would preclude a patient from receiving durvalumab? Is there any patient with stage III NSCLC who should not get durvalumab?
- How quickly do you typically get patients on durvalumab? Is it possible to start it within 14 days?
- Does synergy of CRT with durvalumab persist 4 months out?
- Would you treat a patient with stage II unresectable lung cancer who received cCRT? How about a stage III patient who received sequential CRT?
- What therapeutic options would you consider for stage III patients that progress on durvalumab consolidation?

Conclusions

- Prior to attending CME/CE-certified symposia in 2018, most HCPs were not optimally treating unresectable stage III NSCLC
- These data were consistent over time and, with the FAQs, suggest there is a persistent challenge and educational need on this new treatment modality in this setting
- Posteducation data suggest that HCPs are willing to modify their practice in this setting after receiving expert led education and guidance

References

- Antonia SJ, et al. N Engl J Med. 2017;377:1919-1929.
- Antonia SJ, et al. N Engl J Med. 2018;379:2342-2350.
- Durvalumab PI. Wilmington, DE: AstraZeneca; 2018.

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